Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JUAN CAPELLO, MD
PO BOX 741865
DALLAS TX 75374

Respondent Name

TEXAS A&M UNIVERSITY SYSTEM

Carrier's Austin Representative Box

Box Number 29

MFDR Tracking Number

M4-11-2062-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS. REQUIRED TESTING BY THE DD"

Amount in Dispute: $524.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor is requesting dispute resolution for CPT code 99456 with modifier codes of WP and W5, for Designated Doctor Examinations addressing maximum medical improvement and Impairment. The 99456-WP-W5 was denied with ANSI reduction code of 115. The audit notes state that the injured worker was assigned MMI/IR by the treating doctor. Both parties agreed to cancel the Designated Doctor Evaluation. Notification of canceled appointment was made on 10/21/10. Please see attachment #1, the TDI-DWC Laredo office formally cancelled the evaluation. The requestor is also requesting dispute resolution for CPT code 95851 – range of motion (ROM) measurement. The 95851 was denied with ANSI reduction code of 97. The audit notes state ROM is global to the MMI/IR. Per TDI-DWC rule 134.204(j)(1)(E), the MMI/IR examination include tests used to assign the IR, as outlined in the AMA guides to the Evaluation of Permanent Impairment."

Response Submitted by: Starr Comprehensive Solutions, Inc., P.O. Box 801464, Houston, Texas 77280-1464

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2010	99456-WP-W5 and 95851	$524.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 10, 2010
   - 97 – Payment is included in the allowance for another service/procedure
   - 97 – ROM IS GLOBAL OF THE MMI/IR.
   - 16 – Documentation does not support billed services
   - 16 – DOCUMENTATION DOES NOT SUPPORT BILLING. NO DWC-69 FORM RECEIVED.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 115 – Procedure postponed or canceled.
   - 115 – THE INJURED EMPLOYEE WAS ASSIGNED MMI/IR BY THE TREATING DOCTOR. BOTH PARTIES AGREED TO CANCEL THE DESIGNATED DOCTOR EVALUATION. NOTIFICATION OF CANCELED APPOINTMENT WAS MADE 10/21/2010.

   Explanation of benefits dated December 27, 2010 by the respondent with the following reason codes:
   - 97 – Payment is included in the allowance for another service/procedure
   - 16 – Documentation does not support billed services
   - 16 – DOCUMENTATION DOES NOT SUPPORT BILLING. NO DWC-69 FORM RECEIVED.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 115 – Procedure postponed or canceled.
   - 115 – THE INJURED EMPLOYEE WAS ASSIGNED MMI/IR BY THE TREATING DOCTOR. BOTH PARTIES AGREED TO CANCEL THE DESIGNATED DOCTOR EVALUATION. NOTIFICATION OF CANCELED APPOINTMENT WAS MADE 10/21/2010.

Issues

1. Did the Respondent show that the Designated Doctor Services had been cancelled with proper DWC notification to all parties?
2. While the overall service was canceled, the Respondent brought up the global denial per code 97 for range of motion testing (ROM)to the performance of an MMI/IR as a separate line item.
3. Is the Requestor due any reimbursement?

Findings

1. Designated Doctor examination was scheduled via DWC EES-14 to be performed on October 22, 2010 with Requestor.
2. However, the service was cancelled as the treating doctor and the carrier and injured worker agreed to do so after treating doctor had rendered a MMI/IR determination. A notice from the TDI-DWC Laredo field office was provided October 21, 2010 to all parties.
3. Had the service not been canceled, the rules of 28 Texas Administrative Code §134.204 would be in effect to determine reimbursement as per the testing performed and determinations requested and documented as rendered. The Respondent brings up the global nature of (ROM) testing done in addition to the MMI/IR determination. This is a global component of such an examination. If other issues such as Return to Work or Extent of Injury were being addressed rather than MMI/IR, it would not be a global issue if only those types of RTW/EMC questions were addressed. They were not in this billing, therefore it would be properly denied as global in this billing.
4. In accordance with 28 Texas Administrative Code §134.204, the requestor is not entitled to reimbursement for services properly canceled.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 20, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.